STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355115	A. BUILDING _____ B. WING _____	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	407 3RD AVE SE GARRISON, ND 58540

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification survey conducted on 12/19/2023 found Garrison Memorial Hospital Nursing Facility in compliance with the requirements of 483.73 Long-Term Care Facilities Emergency Preparedness.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/29/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

North Dakota Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1076	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**12/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	**407 3RD AVE SE** **GARRISON, ND 58540**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L3820	33-07-04.2-08,2 PLANS AND SPECIFICATIONS A facility shall submit plans and specifications to the department for all construction, remodeling, and installations subject to review. The plans and specifications must be prepared by an architect or engineer licensed in North Dakota, unless otherwise determined by the department. This State Licensing Rule is not met as evidenced by: The facility failed to submit plans and specifications to the department for construction which was subject to review and approval. On 12/19/2023, observation and staff interview determined the facility had installed a sidewalk outside the west exit to the parking lot. The sidewalk was a component of the exit discharge from the building. There was no previous sidewalk in this means of egress. The facility failed to submit plans for approval to the ND Department of Health and Human Services. Failure to submit plans for review and receive construction approval as required increases the risk of death or injury due to fire. The deficiency affected one (1) of three (3) paths of egress from the facility.	L3820	1. Address how corrective action will be accomplished for those residents that have been affected by the deficient practice. The plans from the sidewalk were obtained and submitted to Karla Aldinger, ND Dept of Health & Human Services, Life Safety & Construction Unit Director to review. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Review of the plans will determine if the construction to the sidewalk that has already been completed is approved. 3. Address what measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur. We will create a policy stating that all future construction or remodel plans for our facility need to be submitted to the ND Department of Health and Human Services Life Safety & Construction Unit	12/29/23

Health Repsonse and Licensure

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/29/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1076	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**12/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	**407 3RD AVE SE** **GARRISON, ND 58540**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L3820	Continued From page 1	L3820	for approval. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Facilities Manager will ensure all future construction or remodel plans are signed off by the Life Safety & Construction Unit for approval before any work will take place. 5. Include dates when corrective action will be completed. Will be completed by January 31st 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	**407 3RD AVE SE** **GARRISON, ND 58540**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This survey used the 2012 edition of NFPA 101, Life Safety Code, Chapter 19-Existing Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code in compliance with 42 CFR 483.70(a)(b). The findings that follow demonstrate noncompliance with these standards. The facility was located in a two-story building of Type II (000) construction with a basement. The building had a wet automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. An occupancy separation wall constructed to have a two-hour fire resistance rating separated a clinic building to the east from the hospital. The nursing facility occupied the second floor of the hospital.	K 000		
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: The facility failed to ensure smoke detectors were installed, maintained, inspected and tested in accordance with NFPA 72, National Fire Alarm and Signaling Code. Sensitivity testing of smoke detectors is to be completed for all smoke detectors during the first year in service, and the alternate year following. After the second required calibration test, if the	K 347	1. Address how corrective action will be accomplished for those residents that have been affected by the deficient practice. The sensitivity testing will be completed in January 2024. 2. Address how the facility will identify other residents having the potential to be	12/29/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/29/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	**407 3RD AVE SE** **GARRISON, ND 58540**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 347	Continued From page 1 detector has remained within its listed and marked sensitivity range, the length of time between calibration tests may be extended, not to exceed five years. 19.3.4.5, 9.6.2.10.1.1, NFPA 72 14.4.5.3 Review of the fire alarm test results indicated the smoke detection system did not have sensitivity testing at frequencies in compliance with the minimum requirements of NFPA 72. No records were available to indicate smoke detectors were sensitivity tested at the required two-year test interval. Failure to install, maintain, inspect and test the smoke detection system in accordance with NFPA 72 increases the risk of death or injury due to fire. This deficiency affected all smoke detectors in the facility.	K 347	affected by the same deficient practice. The annual inspection for the fire alarm system will include the sensitivity for the whole building. 3. Address what measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur. We will create a recurring PM that comes out every other year to make sure the annual inspection includes sensitivity testing. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. We will be viewing reports before they leave the site and will sign off if the testing has been completed. 5. Include dates when corrective actions will be completed. Will be completed by January 31, 2024.	